A. Yes.

Q. About how often have you done that?

A. How often?

Q. Yes.

A. It's not that frequent, but I cannot give a number.

Q. More than once?

A. More than once.

Q. More than twice?

A. More than twice.

Q. More than three times?

A. I think so. As far as I can remember, more than three times.

Q. What is your understanding of the requirements for involuntary hospitalization under Mental Hygiene Law 9.39?

A. You are saying hospitalization for emergency status, right?

Q. 9.39, which I guess the law characterizes as emergency status.

A. As far as I can recall, the person is suffering from a mental illness and at the time of admission he poses a risk to the safety

of himself or the safety of others.

It's also that he also may be having impaired judgment, that he is unable to care for himself, thus endangering himself.

Q. Any other requirements, to the best of your knowledge, for involuntary hospitalization under 9.39?

A. If there is a -- as far as I can recall, with the 9.39 there might be -- let me.

You are asking if there is another, as to the best of my knowledge?

Q. If to the best of your knowledge there are any other requirements for involuntary hospitalization.

A. There may be, but at this time I cannot remember, and I have to kind of like maybe have to review the paper.

Q. Now, to the best of your understanding what is the difference, if any, between the legal criteria of 9.27 and the legal criteria of 9.39?

A. The similarities with both is involuntary.

Q. I'm sorry?

A. Well, the thing is, yes, because the basis of facts and information where she was hospitalized there by transfer history of psychiatric, I got that from the records from the transfer.

Q. Okay. So is what you wrote the reasons why you believe the patient was dangerous?

A. She has -- she has a temper. She has to work on her temper; but awareness that she doesn't know what causes the aggressivity, that is -- that's the fact that when I saw her, which she is on a one-to-one. So that is a sign that she is a danger, a risk.

Q. I guess my question to you is, are the reasons or the facts set forth in your handwriting the reasons why you believed that Ms. Carter was dangerous?

A. Yes, based on the facts and information I have obtained, yes.

Q. Is your practice to always write down the reasons why you believe a patient is dangerous, on these two patient certificate forms?

A. Yes.

Q. If this paranoid patient thought the way you said she thought, couldn't you say that she was not going to or couldn't you say she had an intent to act on paranoia if challenged by others?

MR. PEEPLES: Objection to form.

A. Intent to act. If I talk to her, and then she says I want to hurt her, then I have to place her on a one-to-one because that is a definite threat to safety of others.

Q. Why don't you agree that a paranoid person who poses -- sorry.

Wouldn't you agree that a paranoid person who has an intent to act on paranoia poses a far greater risk of causing harm than she would have if she has no such intent to act?

MR. PEEPLES: Objection to form.

A. The likelihood is greater, yes.

Q. Would you agree further, Doctor, that a paranoid person who has a history of acting on paranoid thoughts in the past poses a

far greater risk of harm than she would if she had no such history of acting on the paranoia?

MR. PEEPLES: Objection to form.

A. The history -- of course it depends upon the situation, but based upon my education and my assessment and my level of training, the history of past behavior influences the present.

Q. So wouldn't you agree that if this person had a history of acting on the paranoia in the past then that person would pose a greater risk than she would if she did not have such a history?

A. Yes.

Q. When assessing danger, which is a more important clinical fact to know, if a person is paranoid or a person has a history of acting on paranoia?

A. Both, I would say.

Q. Would you say that both are equally important?

A. Yes.

Q. Why is that?

A. Because if a person is currently paranoid but, for example, doesn't have, for example, this was the first break and the paranoid thoughts are so intense, the delusions are so intense that the person has the risk of acting up on it, that's dangerous.

Now, granting the fact that the person has -- if the person has a history of it also would substantiate more that because of that history it would.

Q. All right. Well, let me ask you this, Doctor, when assessing the dangers of a paranoid person is it important to know the nature of the paranoia?

A. It is important to know the nature and the content of the delusions.

Q. Which is more important, knowing that the person is paranoid or knowing the content of the particular paranoid delusions?

A. The content of paranoid delusions.

Q. Would you agree, Doctor, that it's more important to know the content because some paranoid people are not dangerous and you really have to know more than whether a person is

A. We are looking at the basic needs of the person. If the person was, let's say, not eating, okay, but not just one day, but the person comes in, you know, very thin --

Q. So would you say the person suffered from malnutrition?

A. Well, yes. Once the blood work is done, which is usually done in the emergency room, they show all the blood work that is very abnormal, the glucose is very low, the electrolytes are very low, then definitely the person has some medical problems that should be addressed; and then the person still doesn't want to be treated for that, unable to care for themselves.

And because of that, if it's not treated or his needs are not addressed, then the person will get more sick and be a danger to themselves.

Q. Would you agree, Doctor, that when you say cannot care for themselves that's a conclusion, correct?

A. Conclusion, yes.

Q. Wouldn't you agree further,

Doctor, you have to look at certain information that will allow you to reach that conclusion?

A. Yes.

Q. I'm concerned about the information you look at.

A. Okay.

Q. Is whether or not a person was dehydrated something you would look at?

A. Yes.

Q. How about if the person had other physical illnesses that went untreated?

A. Yes.

Q. How about whether a person had a willingness to accept treatment?

A. Yes.

Q. How about a willingness, a willingness to accept treatment on an outpatient basis?

A. Unwillingness to accept treatment on an inpatient basis?

Q. Or a willingness. Either one, willingness or unwillingness. All right.

A. Let's see. Where the person -- the person has good judgment, not impaired

judgment, because the willingness of a person to undergo treatment depends upon the person's judgment, and then if the judgment is present and he undergoes treatment, then it would be helpful that outpatient would be appropriate.

Q. Let me ask you this, Doctor, would you agree that a person might have poor judgment and not want treatment and yet have the ability to meet his food need?

MR. PEEPLES: Objection to form.

A. That's difficult to answer because if a person has poor judgment how will he know what he will need?

I mean if he thinks that eating from the garbage is his good judgment, that's poor judgment to us. It's not within the norm of society or within the normal standard.

Q. I guess my question to you, Doctor, is, from a psychiatric and clinical perspective can a person manifest poor judgment in some ways and yet have it enough together to know that he's got to eat food that is not unsanitary?

A. Some judgment in some ways, possibly, yes.

Q. So you would agree, Doctor, that simply because a person has impaired judgment that doesn't render the person unable to meet his food needs, correct?

A. Repeat that, please.

Q. You would agree, Doctor, that simply because a person has poor judgment in some ways does not mean the person lacks the ability to meet his food needs?

MR. PEEPLES: Objection to form.

A. Yes.

Q. So would you agree that when making an assessment of danger because of an inability to meet needs, if you had a person with poor judgment you would want to know to what degree this judgment interfered with the person's ability to meet his essential needs of food?

A. Yes, among other things, yes.

Q. Is it important to know whether or not such a person had family members who were

willing and able to provide support in the community?

A. Yes, it's important.

Q. Would it be important to know whether or not this person is able to handle money in a way to help make minimal self-maintenance transactions?

A. Yes.

Q. Would it be important to know whether or not the person was living in squalor?

A. Yes.

Q. Now, Doctor, let's say you were evaluating a 730.40 patient, correct?

A. Yes.

Q. That patient would be coming from jail, correct?

A. Some of them, yes, straight from Riker's.

Q. Where else would they be coming from?

A. From Kings County, Bellevue.

Q. So they would be coming from some sort of institutional setting, not the street?

A. Yes.

Q. Would you agree, Doctor, that when a person comes from the street it is highly unlikely --

MR. BROOKS: Withdrawn.

Q. Would you agree, Doctor, that when a person is coming from some sort of institutional setting and not the street the person will not suffer from malnutrition, dehydration, or have medical needs unmet, correct?

MR. PEEPLES: Objection to form.

A. Yes, because then he would have been given the proper treatment there, if he -- this is working under the assumption that he agrees, is working with the doctor over there in the hospital.

Q. So wouldn't you have to know, Doctor, how the patient was doing prior to being arrested and being taken to jail?

A. Yes. It's important to know that, yes. Because in the forensic information they would describe the age, where the person was picked up, when he became a homeless person,

hospital was not forcing the clinicians to look at certain risk criteria?

MR. PEEPLES: Objection to form.

A. More accurate you say?

Q. Yes.

A. Personally, I think that the risk assessment is a way of safeguarding the person's -- I mean the safety of the public and also kind of like a way of seeing if the person is still safe and not a danger to himself also.

Q. Would you agree, Doctor, that this form requires clinicians to look at certain factors relating to danger? Correct?

A. Yes.

Q. Do you believe it's useful for clinicians to be forced to look at certain criteria relating to danger?

MR. PEEPLES: Objection to form.

A. Forced? We are not forced. It's part of our work training to look at this.

Q. Well, would you say it's useful to have a process that directs clinicians to focus

on certain criteria?

A. Yes.

Q. Would you agree that it's useful because it results in clinicians examining certain data when they might otherwise not do so?

MR. PEEPLES: Objection to form.

A. Yes, it helps.

Q. Would you say it enhances the accuracy of any risk assessment process?

MR. PEEPLES: Objection to form.

A. Yes, it helps.

Q. Would you say it enhances the accuracy of the process?

MR. PEEPLES: Objection to form.

A. It then enhances the accuracy of the process relating to the risk, yes.

Q. Why is that?

A. Because when a person is more stable, more focused, they are able to kind of like discuss. Sometimes the history is not